

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7. rilmG194 3-27-56 et
2811

CERTIFICATE OF DEATH

02793
100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN 1b <i>9 days.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Memorial Hosp.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Maryland and.</i>	
d. STREET ADDRESS <i></i>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ALLAN SPENCER BAILEY</i>		First <i>ALLAN</i>	Middle <i>SPENCER</i>
4. DATE OF DEATH <i>BAILEY</i>	Month <i>MAR</i>	Day <i>16</i>	Year <i>1956</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 14 1881</i>
9. AGE (In years lost birthday) <i>74</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>
13. FATHER'S NAME <i>James Bailey</i>	14. MOTHER'S MAIDEN NAME <i>Philomena</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <i>583X</i>	16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>Frank S Bailey Maryland and.</i>	Address <i></i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhage</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Esophageal varix.</i>			
DUE TO (c) <i>Hepatic obstruction</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Hour o. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Feb</i> , 19 <i>56</i> , to <i>16 Mar</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>16 March</i> , 19 <i>56</i> , and that death occurred at <i>8:45</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>La Plata, Md.</i>			
ACTUAL SIGNATURE <i>Arthur O. Woody</i>	M.D. <i></i>	DATE SIGNED <i></i>	
PHYSICIAN'S NAME (Type) <i>ARTHUR O. WOODY</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/18/56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Maryland Baptist</i>	22d. LOCATION (City, town, or county) (State) <i>Maryland and</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Greenleaf Funeral Home Inc. La Plata</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE <i>3/20/56</i>	24b. REGISTRAR'S SIGNATURE <i>Julia H. Posey</i>

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 22 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-5 10/M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2812 CERTIFICATE OF DEATH

02794

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS		COUNTY Maryland Point	
Charles La Plata Physicians Memorial				Md. Maryland Point			
3. NAME OF DECEASED (First) Ethel Pearl Bastain (Middle) (Last)				4. DATE (Month) OF DEATH 3 20 56			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH 2-5-14	9. AGE last birthday 42	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. (Year) Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Willie Kidd				14. MOTHER'S MAIDEN NAME Minne Williamson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No			16. SOCIAL SECURITY NO.			17. INFORMANT & ADDRESS Oscar Bastain - Md. Point	
18. MEDICAL CERTIFICATION Cancer of Cervix, uterus Oct 1954							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 171X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>get 54</u> , 19 <u>56</u> , to <u>3-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-19</u> , 19 <u>56</u> , and that death occurred at <u>8A.M.</u> from the causes and on the date stated above. SIGNATURE <u>E. Edelin</u> ADDRESS (Street, city, town, state) <u>La Jolla Rd 3-20 56</u> DATE SIGNED <u>3-20 56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-22-56		NAME OF CEMETERY OR CREMATORIAL Nanjemoy Baptist		LOCATION (City, town, or county) Nanjemoy, Md. (State)	
24. REC'D BY REGISTRAR DATE 3/21/56		REGISTRAR'S SIGNATURE Julia H. Passey		25. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home		ADDRESS Wardens	

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MAR 23 1956

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MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

02795

Reg. Plat. No. *105*

105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

<p>1. PLACE OF DEATH: COUNTY Charles</p> <p>CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Gregors Road</p> <p>HOSPITAL OR INSTITUTION OR STREET ADDRESS</p>			<p>MARYLAND</p> <p>LENGTH OF STAY (In this place) 82-Yrs</p> <p>2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Marshall Hall</p> <p>STREET ADDRESS (If rural, give location)</p>		
<p>3. NAME OF DECEASED (Type or Print) John Richard Bryan</p> <p>4. DATE OF DEATH 3-8-56</p>			<p>(Month) (Day) (Year) 3 19</p>		
5. SEX Male	6. COLOR OR RACE W-US	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 3-13-74	9. AGE last birthday 81	If under 1 year Months Days Hours Min.
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer</p> <p>10b. KIND OF BUSINESS OR INDUSTRY Farmer</p>			<p>11. BIRTHPLACE (State or foreign country) Maryland</p> <p>12. CITIZEN OF WHAT COUNTRY? USA</p>		
<p>13. FATHER'S NAME George R. Bryan</p> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No</p> <p>16. SOCIAL SECURITY NO. None</p>			<p>14. MOTHER'S MAIDEN NAME Wilhemina Brown</p> <p>17. INFORMANT AND ADDRESS (Daughter) Frances Grigsby.</p>		
<p>18. MEDICAL CERTIFICATION</p> <p>No</p> <p>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0</p> <p>Immediate cause (a) Arterio Sclerotic Heart Disease</p> <p>Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Senility With Arterio Sclerosis</p> <p>(c)</p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Kidney stone with Kidney colic</p> <p>Unknown</p> <p>19a. DATE OF OPERATION</p> <p>19b. MAJOR FINDINGS OF OPERATION</p> <p>20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>					
<p>21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY</p>		<p>(CITY OR TOWN) (CITY OR TOWN)</p> <p>(COUNTY) (COUNTY)</p> <p>(STATE) (STATE)</p>	
TIME (Month) (Day) (Year) (Hour) TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work	HOW DID INJURY OCCUR? Not while at work			
<p>22. I certify that I took charge of the remains described above, 3-13-56, Inspection <input checked="" type="checkbox"/> Inspection, 3-13-56 thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes</p> <p>SIGNATURE James E. Andrews (Degree or title) Indian Head Md.</p> <p>DATE SIGNED 3-11-56</p>					
<p>23. BURIAL, CREMATION REMOVAL (Specify) Burial</p>		DATE THEREOF 3-13-56	NAME OF CEMETERY OR CREMATORIUM Bumpy Oak Cemetery	<p>LOCATION (City, town, or county) Pomeroy</p> <p>(State) Waldorf</p>	
<p>DATE REC'D BY LOCAL REG. 3-13-56</p>		REGISTRAR'S SIGNATURE Mr. C. Monroe Hunt Funeral Home	<p>24. FUNERAL DIRECTOR Waldorf</p>		

BUREAU V. S

MR 15 1955

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1.55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02796

2814 CERTIFICATE OF DEATH

Reg. Dist. No. 104

Item 8, Film 194 3-27-56 et

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN <u>Waggsides</u>		MARYLAND LENGTH OF STAY (In this place) STATE <u>MD</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Waggsides</u> STREET ADDRESS <u>(If rural give location)</u>		
3. NAME OF DECEASED (Type or Print) <u>Theodore Roosevelt Butler</u>		4. DATE OF DEATH <u>3-13-1956</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 12, 1875</u>	9. AGE last birthday <u>51</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Charles, Md</u>	
13. FATHER'S NAME <u>James H. Butler</u>		14. MOTHER'S MAIDEN NAME <u>Julia Jackson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>123-45-6789</u>	17. INFORMANT & ADDRESS <u>Mary Butler, Waggsides</u>	
18. MEDICAL CERTIFICATION				
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Angina Pectoris</u> INTERVAL BETWEEN ONSET AND DEATH <u>3-13-12</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) <u>Charles, Md</u> (County) <u>Charles</u> (State) <u>Md</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>acute</u> to <u>19</u> , that I last saw the deceased alive on <u>1956</u> and that death occurred at <u>M.</u> from the causes and on the date stated above. SIGNATURE <u>F. J. Edelen</u> M. D. DATE SIGNED <u>La Plata, Md 3-14-56</u> ADDRESS <u>(Street, city, town, state)</u>				
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 19, 1956</u>	NAME OF CEMETERY OR CREMATORIY <u>St. Paul's Cemetery</u>	LOCATION (City, town, or county) <u>Charles, Md</u> (State) <u>Md</u>
24. REC'D BY REGISTRAR DATE <u>MAR 20 1956</u>		REGISTRAR'S SIGNATURE <u>Mr. Tom J. Farny</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home</u> ADDRESS <u>1001 Hunt Street, Charles, Md</u>	

AMERICAN INFORMATION SERVICE
THE STATE DEPARTMENT

REINSTATEMENT OF DEATH

AMERICAN INFORMATION SERVICE
THE STATE DEPARTMENT

REINSTATEMENT

DEATH

AMERICAN
INFORMATION
SERVICE

BUREAU V.A.

MAR 20 1956

KELLY FILE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the words "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2815 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02797

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>La Plata Charles Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <i>JAMES Edward Dyson</i>		4. DATE OF DEATH Last <i>3</i> Month <i>3</i> Day <i>15</i> Year <i>1956</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 9 1920</i> 9. AGE (in years last birthday) <i>36</i> yr. 10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months <i>0</i> Days <i>0</i> Hour <i>0</i> Min. <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HANDY MAN</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Shoaty's Restau</i>	11. BIRTHPLACE (State or foreign country) <i>Beth ALTON MD</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		
13. FATHER'S NAME <i>ROBERT Dyson</i>		14. MOTHER'S MAIDEN NAME <i>ANNIE MILLS</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>CATHERINE Jones (sister)</i> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Coronary Occlusion 3-16-56</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <input type="checkbox"/> p. m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>La Plata</i> (County) <i>Charles</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> ACTUAL SIGNATURE <i>J. Edelen</i> DATE SIGNED <i>3-16-56</i> EXAMINER'S NAME (Type) <i>J. Edelen M.D.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-19-56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Sacred Heart</i>	22d. LOCATION (City, town, or county) <i>La Plata</i> (State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Reeves Inc. La Plata</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>3/19/56</i>	24b. REGISTRAR'S SIGNATURE <i>Julia Noasey</i>	

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

BUREAU V. S.

MAR 21 1956

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MAR 21 1956

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10A

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02798

2816 CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH

COUNTY CHARLES

CITY (If outside corporate limits, write RURAL
OR
end give nearest town)

TOWN LA PLATA

MARYLAND

LENGTH OF STAY
(in this place)

19 DAYS

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

PHYSICIANS' MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND

COUNTY CHARLES

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN HUGHESVILLE, MARYLAND

STREET
ADDRESS

(If rural give location)

ROUTE 5.

3. NAME OF
DECEASED
(Type or Print)

(First)

(Middle)

(Last)

PHILIP STANLEY HARRISON

4. DATE (Month) (Day) (Year)
OF DEATH MARCH 26 1956

5. SEX

6. COLOR OR
RACE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

8. DATE OF BIRTH

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

BANKER (RETIRED)

10b. KIND OF BUSINESS
OR INDUSTRY

BANKING

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

WIRT HARRISON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unk.)

(If Yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

—

17. INFORMANT & ADDRESS

MRS. NELLIE M. HARRISON

HUGHESVILLE, MARYLAND

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

204.1 IMMEDIATE CAUSE (A) ACUTE MYELOGENOUS LEUKEMIA

INTERVAL BETWEEN
ONSET AND DEATH

2 MONTHS

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B) ACUTE PLASTIC ANEMIA 1/6 MONTHS

GIVING RISE TO THE ABOVE CAUSE STATEMENT

STATING UNDERLYING CAUSE LAST. DUE TO

(C) ARTERIO-SCLEROSIS, GENERALIZED 10 YEARS

10 YEARS

10 YEARS

10 YEARS

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO

21a. ACCIDENT WAS UNDERLYING

21b. PLACE (Home, farm, factory,
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While M. at work

Not while M. at work

21f. HOW DID INJURY OCCUR?

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED BY SOURCE

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APR 4 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02799

2817 CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Indian Head (Rural 1) (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS		
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) OF DEATH Dec. 20 (Day) 19 56 (Year)	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Dec. 5, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Naval Powder Factory	11. BIRTHPLACE (State or foreign country) Salisbury, Md.
13. FATHER'S NAME David A. Jenkins		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. David A. Jenkins, RFD Indian Head	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 179x IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Metastatic Carcinoma Prostate</i>		INTERVAL BETWEEN ONSET AND DEATH 2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED M. While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 1954</i> to <i>Dec. 20, 1956</i> , that I last saw the deceased alive on <i>Oct. 11, 1956</i> , and that death occurred at <i>7:45 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>Frank G. Parsons</i> M.D.		ADDRESS (Street, city, town, state) <i>Indian Head Md.</i> DATE SIGNED <i>3-20-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF <i>3-24-56</i> NAME OF CEMETERY OR CREMATORIAL <i>Parsons Cem.</i>	
24. REC'D BY REGISTRAR MAR 23 1956 DATE		REGISTRAR'S SIGNATURE <i>Mrs. Odey Price</i>	
		25. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home</i>	
		ADDRESS <i>W. 9th St., Indian Head</i>	

81. SIGNATURE OF STATE DEPARTMENT OR STATE GOVERNOR

THE CERTIFICATE OF DEATH

DEATH CERTIFICATE

RECEIVE

MAR ~ 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2818

Item 9, Film G196 1-23-56 at

CERTIFICATE OF DEATH

Reg. 828000

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural La Plata		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural La Plata		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION La Plata						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM HENRY Mayer		First	Middle	Last	4. DATE OF DEATH March 27 1956	Month	Day Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Farmer Ret		11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Mayer		14. MOTHER'S MAIDEN NAME Lena Snyders					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
				william h. mayer Jr. La Plata, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		2 min.					
DUE TO		Respiratory collapse					
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b)		Cerebral Vascular Accident 19 hrs.					
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 1950, to March 27, 1956, that I last saw the deceased alive on March 27, 1956, and that death occurred at 7:15 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE Arthur O. Wooddy		DATE SIGNED 3/27/56					
PHYSICIAN'S NAME (Type) Arthur O. Wooddy, M. D.		La Plata, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/29/56		22c. NAME OF CEMETERY OR CREMATORIAL BAPT		22d. LOCATION (City, town, or county) (State) La Plata, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Reinhart Funeral Home Inc. La Plata, Md.				DATE 3/29/56		Julia B. Basye	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

20130518-114930 TAIWANESE STATE: OMARUAN

RECEIVED APR 4 1956 BUREAU V. C.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02801
2819 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 105

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Maria First Niv. Ed. Middle Kerr Last Naylor		4. DATE OF DEATH Month 3 Day 19 Year 1956	
5. SEX F 6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 2-20-1873 9. AGE (In years last birthday) 83 yrs.	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Benjamin Kerr		14. MOTHER'S MAIDEN NAME Vick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO 17. INFORMANT Rev. Roy D. Leavitt - Waldorf Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 3-19-56	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		ACTUAL SIGNATURE M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-20-56 EXAMINER'S NAME (Type) J. E. JELLEN M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/21/56 22c. NAME OF CEMETERY OR CREMATORIAL OAKLAND 22d. LOCATION (City, town, or county) Waldorf (State) 121	
23. FUNERAL DIRECTOR'S SIGNATURE Hurtt Funeral Home Waldorf, Md.		ADDRESS DATE 3-23-1956 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Miss M. L. Monroe	

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MAR 23 1956

REGISTRATION

کوئی تغیرت

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2820

CERTIFICATE OF DEATH

02802

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Plains	
3. NAME OF DECEASED (Type or print) RICHARD		First W	Middle OFFUTT
4. DATE OF DEATH MARCH 2 1956		Last 5/18/1885	Month Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/18/1885
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) merchant		10b. KIND OF BUSINESS OR INDUSTRY Art	
10c. BIRTHPLACE (State or foreign country) Maryland		11. MOTHER'S MAIDEN NAME Annie Jones	
13. FATHER'S NAME Jerome Abbott		14. MOTHER'S MAIDEN NAME Clarence Abbott, Jr., White Plains	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) 204.0		16. SOCIAL SECURITY NO. 17. INFORMANT DUE TO	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>chronic lymphoid</u> <u>leukemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) La Plata, Md.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 1, 1955</u> to <u>2 MARCH 1956</u> that I last saw the deceased alive on <u>1 MARCH 1956</u> , and that death occurred at <u>2 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>F. M. Johnson</u> M.D. ADDRESS (Street, city or town, state) <u>La Plata, Md.</u> DATE SIGNED <u>7-2-56</u> PHYSICIAN'S NAME (Type) <u>F. M. JOHNSON MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/5/56	
22c. NAME OF CEMETERY OR CREMATORIAL St. Marys		22d. LOCATION (City, town, or county) Barnesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Crehart Funeral Home Inc. La Plata, Md.		24a. REC'D BY REGISTRAR DATE 3/5/56	
ADDRESS		24b. REGISTRAR'S SIGNATURE Julia H. Wasey	

JULY 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2821 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02803

Reg. Dist. No.

100

TO DEPUTY MEDICAL EXAMINER: His certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
X MALCOLM				Hughesville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME		First	Middle	Last	4. DATE OF DEATH Month Day Year 3 27 1956
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) X U.S. AIR FORCE		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1921 34 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas station Attendant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Nannie Russell		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) X U.S. AIR FORCE		16. SOCIAL SECURITY NO. 57-34-182		17. INFORMANT John Quade Address Hughesville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7231 DUE TO Internal hemorrhage (Pleural) Crushed Chest				INTERVAL BETWEEN ONSET AND DEATH 3-27-56	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Crushed Chest				3-27-56	
(c) Auto accident				3-27-56	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto which hit telephone pole			
20c. TIME OF INJURY Month, Day, Year 4:50 p.m. 3-27 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)	20f. (City or town) Highway	(County) Calvert
					(State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE E. J. EDELEN		DATE SIGNED 3-17-56			
EXAMINER'S NAME (Type) E. J. EDELEN		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/56	22c. NAME OF CEMETERY OR CREMATORIAL St. Marys	22d. LOCATION (City, town, or county) Brenton, Md	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home		ADDRESS 1010	24a. REC'D BY REGISTRAR APR 4 1956		24b. REGISTRAR'S SIGNATURE Julia Possey

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Surveillance
3-15-56
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Surveillance

APR 4 1956

REGISTRATION
F. I. C. E. R. E. N. (L.)

Surveillance

Surveillance

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 12,14 FilmG194 3-27-56 et

02804

CERTIFICATE OF DEATH

Reg. Dist. No. 100

2822

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Port Tobacco, Md.		c. LENGTH OF STAY IN 1b 00		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Tobacco		d. STREET ADDRESS 00		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Jens		First Middle Jens		4. DATE OF DEATH Rasmussen		Month March	Day 10	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 30 Aug. 1861		9. AGE (In years last birthday) 94 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Denmark		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jens Rasmussen			14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT LFC Kondrup		Address Port Tobacco, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.			Respiratory Failure (b) Arteriosclerosis; cardiorenal disease DUE TO (c) Senility.			INTERVAL BETWEEN ONSET AND DEATH 10 minutes 15 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Shilo m. E.	20f. (City or town) La Plata, Maryland	(County)	(State)	
21. I certify that I attended the deceased from 3 March 1956 to 10 March 1956, that I last saw the deceased alive on 10 March 1956, and that death occurred at 7:00 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) La Plata, Maryland DATE SIGNED 13 March, 1956								
ACTUAL SIGNATURE Dr. A.O. Wooddy		M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/13/56		22c. NAME OF CEMETERY OR CREMATORIAL Shilo m. E.		22d. LOCATION (City, town, or county) Shilo m. E.		
23. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home Inc La Plata, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 3/14/56		24b. REGISTRAR'S SIGNATURE Julia "Perry		

CERTIFICATE OF DEATH

1. NAME OF DECEASED PERSON	2. ADDRESS	3. DATE OF DEATH
4. MANNER OF DEATH	5. CAUSE OF DEATH	6. DEATH CERTIFICATION
7. MOTHER'S NAME	8. FATHER'S NAME	9. MARRIED
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MAR 16 1956

FBI - BUREAU OF INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02805

2823

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		b. COUNTY <i>Charles</i>	
c. LENGTH OF STAY IN 1b <i>166</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hughesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. Memorial Hosp</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>Mary M. Rawlings</i>		4. DATE OF DEATH <i>March 18 1956</i>	Month Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>July 16, 1918</i>	9. AGE (In years last birthday) <i>37 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>William F. Barford</i>	
14. MOTHER'S MAIDEN NAME <i>Martha Montgomery</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>4-20-1</i>	
16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Reginald Rawlings</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Deleusion</i>		INTERVAL BETWEEN ONSET AND DEATH <i>30 hrs.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO <i>Hypertensive Cardiovascular Disease</i>		(c) DUE TO <i>172.</i>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Acute Strangulated Intestinal Obstruction - Int. Intussusception</i>		19. WAS AUTOPSY PERFORMED? <i>NO</i>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>1956</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. g. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 18, 1956</i> to <i>March 18, 1956</i> that I last saw the deceased alive on <i>March 18, 1956</i> , and that death occurred at <i>9:45 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. Parrin Jarboe</i> PHYSICIAN'S NAME (Type) <i>J. PARRIN JARBOE M.D.</i>		ADDRESS (Street, city or town, state) <i>La Plata Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/21/56</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>old Fields</i>		22d. LOCATION (City, town, or county) (State) <i>Hughesville, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Honti Funeral Home</i>		ADDRESS <i>Watkins</i>	
24a. REC'D BY REGISTRAR DATE <i>3/21/56</i>		24b. REGISTRAR'S SIGNATURE <i>Julie H. Hausey</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU Y. S

MAR 23 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2824 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02807

Reg. Dist. No.

100

Items 11, 12, 13, 14, 19, 20, 3-27-56 et

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Paulsboro</i>		b. COUNTY <i>Charles</i>	
c. LENGTH OF STAY IN 1b <i>1 week</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Paulsboro</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i></i>		d. STREET ADDRESS <i></i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Herbert</i>		First <i>JOHN</i>	Middle <i>Striker</i>
4. DATE OF DEATH Month <i>3</i>		Day <i>14</i>	Year <i>1956</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>Oct 2, 1882</i>	
9. AGE (In years last birthday) <i>73</i>		10. IF UNDER 1 YEAR Months <i></i>	
11. IF UNDER 24 HRS. Days <i></i>		12. IF UNDER 24 HRS. Hours <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>331X</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Mrs Harold Chandler</i>		Address <i>Towson Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3-14-56</i>	
DUE TO <i>331X</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i>			
DUE TO <i></i>			
(c) <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> <i>E. J. EDELEN</i>		DATE SIGNED <i>3-15-56</i>	
ACTUAL SIGNATURE <i>E. J. EDELEN</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-15-56</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Greenlawn</i>		22d. LOCATION (City, town, or county) (State) <i>Wayside Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Funerl Funeral Home</i>		ADDRESS <i>Wabbs</i>	
24a. REC'D BY REGISTRAR DATE <i>MAR 20 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Mrs. F. Wills Rosey</i>	

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BUREAU V. S.

MAR 20 1956

REGELYEG

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please excuse the certificate, writing "delayed - pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, or removal.

1

Items 7, 17, MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Wife's name: filmG197 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
5-11-56 1. *Charles* Item 2, Film 196 1-20-56 et 03965
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Marbury MD</i>	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>	c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marbury</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS ----- e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Lloyd</i>	First <i>Thomas</i> Middle <i>Thomas</i> Last 4. DATE OF DEATH March 25 1956			
5. SEX M 6. COLOR OR RACE C 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 28 9. AGE (In years last birthday) 38 yrs.	10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wife: <i>Thelery Thomas</i>	10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <i>Marbury Charles Co MD</i>	12. CITIZEN OF WHAT COUNTRY? <i>MD</i>		
13. FATHER'S NAME <i>Frank Thomas</i>	14. MOTHER'S MAIDEN NAME <i>Minnie Brooks Thomas</i>	Address <i>Thelery Thomas, wife Marbury Md.</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>3220</i> <i>acute pleochistis</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
ACTUAL SIGNATURE <i>William V. Lovitt</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>March 26 1956</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>31</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Montrose Church</i>	22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Montgomery Bros 913 Florida Ave NW</i>	ADDRESS <i>D.C.</i>	24a. REC'D BY REGISTRAR <i>APR 17 1956</i>	24b. REGISTRAR'S SIGNATURE <i>Mrs. F. W. Poage</i>	

WISCONSIN STATE GOVERNMENT OF HEALTH-SANITATION DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

APR 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2826

CERTIFICATE OF DEATH

02848

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Virginia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tompkinsville Culpepper	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b 10 $\frac{1}{2}$ hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Baby Wheeler		4. DATE OF DEATH March 12 1956	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1956
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none - infant		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Nathan Joe Wheeler		14. MOTHER'S MAIDEN NAME Josephine Quors	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Joe Nathan Wheeler, Tompkinsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3-12-56 Atelectasis 3-12-56	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-12-56, 19, to 3-12-56, 19, that I last saw the deceased alive on 3-12-56, 19, and that death occurred at 7:35 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) La Plata, Md.			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) William J. Kurz		DATE SIGNED 3/13/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/56	
22c. NAME OF CEMETERY OR CREMATORIAL Tompkinsville, Tompkinsville, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS La Plata, Tompkinsville, Md.		24a. REC'D. BY REGISTRAR DATE 3/14/56	
		24b. REGISTRAR'S SIGNATURE Julia H. Gazeley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this Certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2002

BUREAU V. S.

MAR 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2827

CERTIFICATE OF DEATH

02809
Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN 1b 9 das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Memorial Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Potomac Bluff MD</i>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>MARY</i>	Middle <i></i>	Last <i>WILLIAMS</i>
4. DATE OF DEATH <i>3/14/56</i>	Month <i>3</i>	Day <i>14</i>	Year <i>1956</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-22-1913</i>
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <i>42 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>332X</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Clarence Clark Potomac Heights</i>		Address <i></i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBROVASCULAR</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>8 DAYS</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i></i>		(b) <i></i>	
		DUE TO (c) <i></i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>POSITIVE SEROLOGICAL TEST FOR SYPHILIS</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6 Mar 1956</i> to <i>14 Mar 1956</i> that I last saw the deceased alive on <i>14 Mar 1956</i> , and that death occurred at <i>7:00 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>611 PLATA, MD</i> DATE SIGNED <i>3-14-56</i>			
ACTUAL SIGNATURE <i>F. M. Johnson M.D.</i>		22. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>3/19/56</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Pomonkey</i>	
22d. LOCATION (City, town, or county) <i>Pomonkey MD</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archibald Funeral Home Inc La Plata MD</i>		24a. REC'D BY REGISTRAR DATE <i>3/19/56</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Julia N. Pasey</i>	

BUREAU V.

MAR 21 1956

RECEIVED